BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JENNIFER LYNN BALES 338 Virginia Drive Livermore, CA 94550 Registered Nurse License No. 583667 Respondent	Case No. 2008-162

DEFAULT DECISION AND ORDER

The attached Default Decision and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in the above entitled matter.

This Decision shall become effective on **April 19, 2008**.

IT IS SO ORDERED **March 19, 2008.**

LaTrancine W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

EDMUND G. BROWN JR.
Attorney General of the State of California
WILBERT E. BENNETT
Supervising Deputy Attorney General
SHANA A. BAGLEY, State Bar No. 169423
Deputy Attorney General
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2129
Facsimile: (510) 622-2270

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNIFER LYNN BALES** 338 Virginia Drive Livermore, CA 94550 Registered Nurse License No. 583667 Respondent.	Case No. 2008-162 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about November 14, 2007, Complainant Ruth Ann Terry, M.P.H., R.N., in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2008-162 against Jennifer Lynn Bales (Respondent) before the Board of Registered Nursing.

2. On or about July 19, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License No. 583667 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2009, unless renewed.

3. On or about November 21, 2007, Shontane McElroy, an employee of the Department of Justice, served by Certified and First Class Mail a copy of the Accusation No. 2008-162, Statement to Respondent, Notice of Defense, Request for Discovery, and Government

Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is: 338 Virginia Drive, Livermore, CA 94550. A copy of the Accusation is attached as Exhibit "A" and is incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about November 23, 2007, a Certified Mail Receipt was signed by the Respondent, acknowledging the receipt of the Accusation and related documents served therewith.

6. Government Code section 11506, subdivision (c), states, in pertinent part:

> The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2008-162.

8. California Government Code section 11520, subdivision (a), states, in pertinent part: "If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the evidence on file herein, finds that the allegations in Accusation No. 2008-162 are true.

10. The total costs for investigation and enforcement are $21,983.75 as of January 18, 2008.

///

///

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Jennifer Lynn Bales has subjected her Registered Nurse License No. 583667 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. A copy of the Accusation is attached.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Respondent's license is subject to disciplinary action under Business and Professions Code (Code) section 2761, subdivision (a)(1), (Unprofessional Conduct: Gross Negligence), as defined by California Code of Regulations, title 16, section 1442, in that while employed as a registered nurse at San Ramon Regional Medical Center in San Ramon, California, she committed acts of gross negligence in carrying out her usual certified or licensed nursing functions for: failing to account for controlled substances; failing to accurately document the care provided (the amount of narcotic medications purportedly administered); withholding care from a patient (in the form of pain relief); diverting narcotic medications; and falsifying patient records upon which the patients are billed (fraud).

b. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a), (Unprofessional Conduct: Obtaining and/or Possessing Controlled Substances or Dangerous Drugs) for unprofessional conduct, as defined by Code section 2762, subdivision (a), in that while employed as a registered nurse at San Ramon Regional Medical Center in San Ramon, California, and at the Art of Aesthetic Surgery in Fremont, California, she committed the following acts: unlawfully obtained and possessed the following controlled substances in violation of Code section 4060: Ambien, Cocaine, Fentanyl, Hydromorphone, Lorazepam, Lortab, Marionol, Meperidine, Morphine, Midazolam, and Vicodin; unlawfully obtained the following controlled substances by fraud, deceit, misrepresentation, subterfuge and/or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a): Ambien, Cocaine, Fentanyl, Hydromorphone, Lorazepam, Lortab, Marionol, Meperidine, Morphine, Midazolam, and Vicodin; unlawfully obtained and possessed

the following dangerous drugs: Cephalexin, Ciprofloxacin, Ephedrine, Furosemide, Neo-Synephrine, Succinyl Choline, and Vecuronium; and unlawfully obtained and possessed the following dangerous devices: syringes and hypodermic needles.

c. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a), (Unprofessional Conduct: Falsify or Make Incorrect or Inconsistent Entries in Records) for unprofessional conduct, as defined by Code section 2761, subdivision (e), and Health and Safety Code section 11190, in that while employed as a registered nurse at San Ramon Regional Medical Center in San Ramon, California, and at the Art of Aesthetic Surgery in Fremont, California, she made false, grossly incorrect, and/or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and dangerous drugs.

d. Respondent's license is subject to disciplinary action under Code section 2761, subdivision (a), (Unprofessional Conduct: Use of Controlled Substances) as defined by Code section 2762, subdivision (b), in that while employed as a registered nurse at the Art of Aesthetic Surgery in Fremont, California, she admittedly used controlled substances and dangerous drugs and dangerous devices to an extent or in a manner dangerous or injurious to herself, any other person, or the public or to the extent that such use impaired her ability to conduct with safety to the public the practice authorized by her license; and

e. Respondent's license is subject to disciplinary action under Code sections 490 and 2761, subdivision (f), (Conviction of Crime Substantially Related to Registered Nursing) in that she was convicted of violating Penal Code section 503 (Embezzlement), a felony, an offense substantially related to the qualifications, functions, and duties of a Registered Nurse, within the meaning of California Code of Regulations, title 16, section 1444.

///

///

///

///

///

///

ORDER

IT IS SO ORDERED that Registered Nurse License No. 583667, heretofore issued to Respondent Jennifer Lynn Bales, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on APRIL 19, 2008.

It is so ORDERED MARCH 19, 2008

La Francene M Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Attachment: Exhibit "A", Accusation No. 2008-162

SF2007900305

Exhibit "A"

Accusation No. 2008-162

EDMUND G. BROWN JR.
Attorney General of the State of California
WILBERT E. BENNETT
Supervising Deputy Attorney General
SHANA A. BAGLEY, State Bar No. 169423
Deputy Attorney General
California Department of Justice
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2129
Facsimile: (510) 622-2270

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNIFER LYNN BALES** 338 Virginia Drive Livermore, CA 94550 Registered Nurse License No. 583667 *Respondent.*	Case No. 2008-162 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H, R.N. (Complainant), brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 19, 2001, the Board of Registered Nursing issued Registered Nurse License Number 583667 to Jennifer Lynn Bales (Respondent). The Registered Nurse License was in effect at all times relevant to the charges brought herein and will expire on January 31, 2009, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 490 of the Code states:

> A board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action which a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

7. Section 2761 of the Code states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

(f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

. . .

8. Section 2762 of the Code states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

9. Section 4022 of the Code provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

///

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

10. Section 4059, subdivision (a), of the Code provides, in pertinent part, that "[n]o person shall furnish any dangerous drug, except upon the prescription of a physician . . ."

11. Section 4060 of the Code provides, in pertinent part that "[n]o person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician . . ."

12. Section 4140 of the Code provides that: "No person shall possess or have under his or her control any hypodermic needle or syringe except when acquired in accordance with this article."

13. Section 11173, subdivision (a), of the Health and Safety Code provides:

No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by concealment of a material fact.

14. Section 11190 of the Health and Safety Code provides, in pertinent part:

(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

(1) The name and address of the patient.

(2) The date.

(3) The character, including the name and strength, and quantity of controlled substances involved.

. . .

///

///

///

///

///

REGULATORY PROVISIONS

15. California Code of Regulations, title 16, section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

16. California Code of Regulations, title 16, section 1444, states:

> A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. . . .

COST RECOVERY

17. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

18. **Ambien** is the brand name for Zolpidem and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11056, subdivision (g), and a dangerous drug within the meaning of Business and Professions Code 4022.

19. **Cephalexin hydrochloride** is a cephalosporin antibiotic and is a dangerous drug within the meaning of Business and Professions Code section 4022.

20. **Ciprofloxacin** is an antibiotic and a dangerous drug within the meaning of Business and Professions Code section 4022.

21. **Cocaine** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (f)(6), and a dangerous drug within the meaning of Business and Professions Code section 4022.

///

22. **Ephedrine** is similar in structure to the synthetic derivatives amphetamine and methamphetamine and is commonly used as a stimulant, appetite suppressant, concentration aid, decongestant, and to treat hypotension. It is a dangerous drug within the meaning of Business and Professions Code section 4022.

23. **Fentanyl** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug within the meaning of Code section 4022.

24. **Furosemide** is a diuretic used to treat congestive heart failure and edema and but is also illicitly used as a masking agent for other drugs. It is a dangerous drug within the meaning of Code section 4022.

25. **Hydromorphone** is the generic name for the trade name drug Dilaudid. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022.

26. **Lorazepam** is a benzodiazepine with CNS depressant, anxiolytic, and sedative properties. It is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057, subdivision (d)(13), and a dangerous drug within the meaning of Business and Professions Code section 4022.

27. **Lortab** is the brand name for the narcotic substance Hydrocodone (a semisynthetic narcotic analgesic and antitussive with multiple actions qualitatively similar to those of codeine) combined with the non-narcotic substance acetaminophen. It is a Section III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(3), and a dangerous drug within the meaning of Business and Professions Code section 4022.

28. **Marionol** is the brand name for Dronabinol. It is a hallucinogen and cannabinoid and is prescribed as an appetite stimulant, primarily for AIDS, chemotherapy and gastric bypass patients. It is illicitly used for its psychedelic side-effects. It is a Section III controlled substance pursuant to Health and Safety Code section 11056, subdivision (h), and a dangerous drug within the meaning of Business and Professions Code section 4022.

///

29. **Meperidine hydrochloride** is the generic name for the trade name drug Demerol, a derivative of Pethidine. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(17), and a dangerous drug within the meaning of Code section 4022.

30. **Midazolam** is the generic name for the trade name drug Versed, a benzodiazepine. It is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057, subdivision (d), and a dangerous drug within the meaning of Business and Professions Code section 4022.

31. **Morphine** or **Morphine Sulfate** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022.

32. **Neo-Synephrine** is the brand name for Phenylephrine and is used as a decongestant. It is commonly used as a stimulant and, in prescription strength, is a dangerous drug within the meaning of Code section 4022.

33. **Succinyl Choline** is also known as Succinylcholine and is widely used in emergency medicine and anesthesia to induce muscle relaxation. It is a dangerous drug within the meaning of Business and Professions Code section 4022.

34. **Vecuronium** is widely used in emergency medicine and anesthesia to induce muscle relaxation. It is a dangerous drug within the meaning of Business and Professions Code section 4022.

35. **Vicodin** is the brand name for Hydrocodone Bitartrate (a semisynthetic narcotic analgesic and antitussive with multiple actions qualitatively similar to those of codeine) & Acetaminophen. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug within the meaning of Business and Professions Code section 4022.

///

///

///

FACTUAL STATEMENT

San Ramon Regional Medical Center

36. From on or about October 2, 2002 to June 3, 2003, Respondent worked as a registered nurse at San Ramon Regional Medical Center located in San Ramon, California. During the course of her employment, Respondent committed the following acts:

a. On or about January 16, 2003 at 0730 hours, Respondent created a temporary user account on the Omnicell Operational Cabinet system[1] ("Omnicell system"). At 0731 hours, Respondent created a temporary user account under the fictitious name "Tree, Ann."

b. On or about January 27, 2003 at 0803 hours, Respondent logged onto the Omnicell system under the fictitious name "Tree, Ann." At 0804 hours, Respondent logged onto the Omnicell system under her own name. At 0804 hours, Respondent activated a password for the fictitious user "Ann Tree." At 0806 hours, Respondent activated a password under her own user name.

c. **Patient N.B.**[2]

i. On or about January15, 2003, Patient N.B.'s physician ordered Hydromorphone 1mg to be administered every 4 hours, as needed for moderate breakthrough pain and Hydromorphone 2mg to be administered every 4 hours, as needed for severe breakthrough pain.

ii. On or about January 16, 2003, at approximately 0828 hours, using the fictitious name "Ann Tree," Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient N.B. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. Respondent was not charged with the care of Patient N.B. during her shift.

---

1. Omnicell and Suremed are systems for the automated dispensing and management of medications at the point of use in hospital settings.

2. All patients are identified by initials in order to preserve patient confidentiality. The medical record numbers of these patients will be disclosed pursuant to a request for discovery.

d. **Patient C.S.**

i. On or about January 15, 2003, Patient C.S.'s physician ordered Hydromorphone 4mg to be administered every 2 hours, as needed.

ii. On or about January 16, 2003, at approximately 1003 hours, using the fictitious name "Ann Tree," Respondent obtained a 4mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient C.S. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about January 16, 2003, at approximately 1126 hours, using the fictitious name "Ann Tree," Respondent obtained two 4mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient C.S. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iv. On or about January 16, 2003, at approximately 1410 hours, using the fictitious name "Ann Tree," Respondent obtained two 4mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient C.S. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

v. Documentation in Patient C.S.'s medical administration record indicated that at 0915, 1340, and 1630 hours, the actual nurse assigned to the patient administered Hydromorphone 4mg to the patient.

vi. Respondent was not charged with the care of Patient C.S. during her shift and Patient C.S. was located in a different unit than where Respondent was assigned.

///

///

///

e. **Patient R.C.**

i. On or about January 25, 2003, Patient R.C.'s physician ordered Hydromorphone 1mg to 2mg to be administered every hour, as needed.

ii. On or about January 27, 2003, at approximately 0808 hours, using the fictitious name "Ann Tree," Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient R.C. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about January 27, 2003, at approximately 1338 hours, using the fictitious name "Ann Tree," Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient R.C. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

iv. Respondent was not charged with the care of Patient R.C. during her shift.

v. On or about January 27, 2003, Patient R.C.'s actual nurse documented in the medical records that at 1200 hours, the patient denied having a headache or discomfort and at 1400 hours the patient was sleeping and had no complaints of pain.

f. **Patient L.F.**

i. On or about January 26, 2003, Patient L.F.'s physician ordered Hydromorphone 2mg to be administered every 2 hours, as needed for pain.

ii. On or about January 27, 2003, at 0914 hours, using the fictitious name "Ann Tree," Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient L.F. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

///

///

iii. On or about January 27, 2003, at 1228 hours, using the fictitious name "Ann Tree," Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient L.F. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

iv. Respondent was not charged with the care of Patient L.F. during her shift.

v. On or about January 27, 2003, Patient L.F.'s actual nurse documented in the medical records that at 0900 hours, the patient reported to be without pain and discomfort. Documentation in Patient L.F.'s medication administration record indicated that at 1400 hours, the patient's actual nurse administered Hydromorphone 2mg to the patient.

g. **Patient G.T.**

i. On or about January 22, 2003, Patient G.T.'s physician ordered Hydromorphone 1mg to be administered every 4 hours, as needed for pain.

ii. On or about January 27, 2003, at approximately 1110 hours, using the fictitious name "Ann Tree," Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient G.T. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. Respondent was not charged with the care of Patient G.T. during her shift and Patient G.T. was located in a different unit than where Respondent was assigned.

h. **Patient L.K.**

i. On or about October 22, 2002, Patient L.K..'s physician ordered Meperidine 100mg to be administered every 3 hours, as needed for severe pain.

///

///

///

///

ii. On or about October 23, 2002 at approximately 1124 hours, Respondent obtained a 100mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient L.K. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

i. **Patient F.M.**

i. On or about October 18, 2002, Patient F.M.'s physician ordered Meperidine 100mg to be administered every 3 hours, as needed for severe pain.

ii. On or about October 19, 2002 at approximately 1202 and 1433 hours, Respondent obtained a 100mg dose of Meperidine from the Omnicell system allegedly for administration to Patient F.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about October 19, 2002 at approximately 1200 hours, Patient F.M.'s medical records indicate that the patient was already being administered Morphine PCA (Patient Controlled Analgesia) with good relief.

j. **Patient D.T.**

i. On or about November 25, 2002, Patient D.T.'s physician ordered Hydromorphone 2mg to be administered every 4 hours, as needed for pain.

ii. On or about November 27, 2002 at approximately 1250 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient D.T. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. Respondent had previously documented the administration of a 2mg dose of Hydromorphone to the patient at approximately 1225 hours.

///

///

///

k. **Patient K.R.**

i. On or about November 19, 2002, Patient K.R.'s physician ordered Hydromorphone 2mg to be administered every hour, as needed.

ii. On or about November 19, 2002 at approximately 1202 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient K.R. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. Respondent had previously obtained a 2mg dosage of Hydromorphone from the Omnicell system at 1123 hours and documented the administration of a 2mg dose of Hydromorphone to the patient at approximately 1135 hours.

l. **Patient L.G.**

i. On or about November 26, 2002, Patient L.G.'s physician ordered Hydromorphone 0.5mg to be administered every hour, as needed.

ii. On or about November 27, 2002 at approximately 0830 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient L.G. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about November 27, 2002 at approximately 1049 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient L.G. Respondent documented the administration of .05mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

iv. On or about November 27, 2002 at approximately 1416 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient L.G. Respondent documented the administration of .05mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

m. **Patient G.B.**

i. On or about December 2, 2002, Patient G.B.'s physician ordered Hydromorphone 1mg to be administered every 2 hours, as needed for moderate pain and Hydromorphone 2mg to be administered every 2 hours, as needed for severe pain.

ii. On or about December 3, 2002 at approximately 0756 and 1310 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient G.B. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

ii. On or about December 3, 2002 at approximately 0921 and 1116 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient G.B. Respondent documented the administration of 1mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

n. **Patient B.M.**

i. On or about December 3, 2002, Patient B.M.'s physician ordered Hydromorphone 2mg to be administered every 2 hours, as needed, Lorazepam 1mg every 30 minutes, as needed, and Hydromorphone 2mg to 4mg to be administered every 2 hours, as needed.

ii. On or about December 6, 2002 at approximately 0848 and 0856 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient B.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about December 6, 2002 at approximately 1422 hours, Respondent obtained a 2mg dose of Lorazepam from the Omnicell system allegedly for administration to Patient B.M. Respondent failed to document the administration of the medication on the

///

patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

iv. On or about December 6, 2002 at approximately 1047 hours, Respondent obtained two 4mg doses of Hydromorphone and at approximately1819 and 1856 hours, Respondent obtained a 4mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient B.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. Respondent had also obtained a 4mg dosage of Hydromorphone from the Omnicell system at 1241, 1422, 1650, and 1857 hours and documented the administration of 4mg doses of Hydromorphone to the patient.

o. **Patient H.M.**

i. On or about January 6, 2003, Patient H.M.'s physician ordered Hydromorphone 1mg to be administered every 2 hours, as needed for pain.

ii. On or about January 7, 2003 at approximately 0902 and 1156 hours, Respondent obtained a 2mg dose of Hydromorphone and at approximately 1418 hours, Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient H.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about January 8, 2003 at approximately 1301 hours, Respondent obtained a 2mg dose of Hydromorphone and at approximately 1439 hours, Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient H.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

///

///

iv. On or about January 8, 2003 at approximately 0850 and 1115 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient H.M. Respondent documented the administration of 1mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

p. **Patient Z.G.**

i. On or about January 14, 2003, Patient Z.G.'s physician ordered Hydromorphone 1mg to be administered every 2 hours, as needed for moderate to severe pain. On or about January 15, 2003, Patient Z.G.'s physician ordered Vicodin 5mg to be administered every 4 hours, as needed for moderate pain.

ii. On or about January 16, 2003 at approximately 0748, 1135, and 1411 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient Z.G. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders. At approximately 1135 and 1544 hours, Respondent had also obtained a 5mg dosage of Vicodin from the Omnicell system and documented the administration of Vicodin to the patient.

q. **Patient N.M.**

i. On or about January 16, 2003, Patient N.M.'s physician ordered Hydromorphone 2mg to be administered every 2 hours, as needed for pain. On or about January 16, 2003, Patient N.M.'s physician ordered Vicodin to be administered every 4 hours, as needed for pain.

ii. On or about January 20, 2003 at approximately 0833 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient N.M. Respondent failed to document the administration of the medication on the

///

///

patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. At approximately 0900 hours, Respondent documented the administration of Vicodin to the patient.

r. **Patient P.M.**

i. On or about January 26, 2003, Patient P.M.'s physician ordered Hydromorphone 1mg to be administered every hour, as needed for pain. On or about January 16, 2003, Patient P.M.'s physician ordered 2 tablets Vicodin 5mg to be administered every 4 hours, as needed.

ii. On or about January 28, 2003 at approximately 0819 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient P.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. At approximately 0819 hours, Respondent obtained 2 tablets of Vicodin, at approximately 0820 hours, Respondent obtained 2 tablets of Vicodin, and at approximately 0822 hours, Respondent obtained 1 tablet of Vicodin from the Omnicell system, all allegedly for administration to Patient P.M. The amount of medication removed exceeded the amount indicated in the physician's orders. Respondent only documented a single administration of Vicodin to the patient but failed to document the dosage administered. Respondent did not chart the wastage of the medication.

s. **Patient R.H.**

i. On or about January 8, 2003, Patient R.H.'s physician ordered Hydromorphone 2mg to be administered every 4 hours, as needed.

ii. On or about January 13, 2003 at approximately 0840 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient R.H. Respondent failed to document the administration of the medication on the patient's medication administration record. However, Respondent originally wrote in the nurses

///

notes that "patient denies pain and discomfort" but crossed it out and added "medicated with Dilaudid 2mg for pain."

t. **Patient N.N.**

i. On or about January 11, 2003, Patient N.N.'s physician ordered Hydromorphone 4mg to be administered every 2 hours, as needed for severe pain.

ii. On or about January 13, 2003 at approximately 0936 hours, Respondent obtained a 4mg dose of Hydromorphone and at approximately 1409 hours, Respondent obtained two 4mg doses from the Omnicell system allegedly for administration to Patient N.N. Respondent failed to document the administration of the 0936 dose and charted only one dose of the 1409 doses on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the remainder of the medication. At approximately 0752 and 1206 hours, Respondent had also obtained a 4mg dose of Hydromorphone from the Omnicell system and documented the administration to the patient.

u. **Patient J.R.**

i. On or about January 8, 2003, Patient J.R.'s physician ordered Lortab Elixir 15ml to be administered every 4 hours, as needed.

ii. On or about January 10, 2003 at approximately 1528 hours, Respondent obtained a 15ml dose of Lortab from the Omnicell system allegedly for administration to Patient J.R. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. Respondent was not charged with the care of Patient J.R. during her shift.

iv. On or about January 10, 2003, Patient J.R.'s actual nurse documented in the medical records that at 1500 hours, the patient was without signs and symptoms of discomfort.

///

///

///

v. **Patient W.M.**

i. On or about January 7, 2003, Patient W.M.'s physician ordered Hydromorphone 1mg to be administered every hour, as needed.

ii. On or about January 9, 2003 at approximately 0824 and 1027 hours, Respondent obtained a 2mg dose of Hydromorphone and at approximately 1214 hours, Respondent obtained two 2mg doses from the Omnicell system allegedly for administration to Patient W.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. At approximately 1446 hours, Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient W.M. Respondent documented the administration of 1mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

iv. At approximately 0824 hours, Respondent had also obtained a 2mg dose of Morphine and at approximately 1037 and 1351 hours, Respondent had also obtained a 4mg dose of Morphine from the Omnicell system and documented the administration to the patient.

w. **Patient J.F.**

i. On or about December 23, 2002, Patient J.F.'s physician ordered Hydromorphone 1mg to be administered every 2 hours, as needed.

ii. On or about December 23, 2002 at approximately 1240 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient J.F. Respondent documented the administration of 1mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

///

///

///

x. **Patient R.L.**

i. On or about December 22, 2002, Patient R.L.'s physician ordered Hydromorphone 1mg to be administered every 2 hours, as needed.

ii. On or about December 23, 2002 at approximately 1439 hours, Respondent obtained two 2mg doses of Hydromorphone from the Omnicell system allegedly for administration to Patient R.L. Respondent failed to document the administration of one of the doses of medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for one of the doses of medication.

iii. On or about December 23, 2002 at approximately 0803 and 0931 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient R.L. Respondent documented the administration of 1mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

y. **Patient S.T.**

i. On or about December 18, 2002, Patient S.T.'s physician ordered a Hydromorphone PCA 10mg syringe with a 2mg per hour limit and Hydromorphone 2mg every 2 hours as needed if the IV infiltrates and cannot restart.

ii. On or about December 19, 2002 at approximately 0801 and 1126 hours, Respondent obtained a 10mg syringe of Hydromorphone from the Omnicell system allegedly for administration to Patient S.T. The documentation on the PCA Flowsheet indicated a syringe change at 0801 hours, however, the flowrate documentation indicated that no new syringe was hung at 1126 hours.

iii. On or about December 19, 2002 at approximately 0759 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient S.T. Respondent documented the administration of 1mg of the medication on the patient's medication administration record, but Respondent failed to chart the wastage of or otherwise account for the remainder of the medication.

///

z. **Patient G.H.**

i. On or about November 25, 2002, Patient G.H.'s physician ordered Meperidine100mg to be administered 3 hours, as needed for severe pain.

ii. On or about November 26, 2002 at approximately 0951 and 1224 hours, Respondent obtained a 100mg dose of Meperidine from the Omnicell system allegedly for administration to Patient G.H. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. At approximately 1100 and 1345 hours, Respondent documented the administration of Vicodin 5mg to the patient.

aa. **Patient D.T.2.**

i. On or about November 25, 2002, Patient D.T.2.'s physician ordered Hydromorphone 2mg to be administered every 4 hours, as needed.

ii. On or about November 26, 2002 at approximately 1321 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient D.T.2. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

bb. **Patient P.M.2.**

i. On or about November 25, 2002, Patient P.M.2.'s physician ordered Meperidine 25mg to be administered every hour, as needed.

ii. On or about November 25, 2002 at approximately 0832 hours, Respondent obtained a 25mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient P.M.2. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about November 25, 2002 at approximately 1427 hours, Respondent obtained a 25mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient P.M.2. At approximately 1400 hours, Respondent documented the administration of

the medication on the patient's medication administration record. However, the patient had been discharged before 1400 hours.

iv. On or about November 25, 2002 at approximately 1256 hours, Respondent documented the administration of a 25mg dose of Hydromorphone to patient P.M.2. Nurses notes from November 25, 2002 indicated that at 0035 hours, the patient had complaints of low level pain but refused pain medication and at 0800 and 1125 hours, the patient had no complaints of pain.

cc. **Patient A.R.**

i. On or about November 25, 2002, Patient A.R.'s physician ordered Hydromorphone 2mg to be administered every 2 hours, as needed.

ii. On or about November 25, 2002 at approximately 1426 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient A.R. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. Respondent was not charged with the care of Patient A.R. during her shift.

dd. **Patient M.M.**

i. On or about November 22, 2002, Patient M.M.'s physician ordered Hydromorphone 2mg to be administered every hour, as needed for breakthrough pain, but to first give the medication orally in tablet form.

ii. On or about November 25, 2002 at approximately 1427 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient M.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. Respondent was not charged with the care of Patient M.M. during her shift.

///

iv. On or about November 25, 2002, Patient M.M.'s actual nurse documented in the medical records that at 1345 hours, the patient was resting quietly without complaints.

ee. **Patient J.F.2**

i. On or about October 21, 2002, Patient J.F.2.'s physician ordered Meperidine 100mg to be administered every 3 hours, as needed for severe pain.

ii. On or about October 22, 2002 at approximately 1112 hours, Respondent obtained a 100mg dose of Meperidine from the Omnicell system allegedly for administration to Patient J.F.2. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

iii. On or about October 22, 2002 from approximately 0800 hours through October 23, 2002 at 0500 hours, Patient J.F.2.'s medical records indicate that Hydromorphone PCA was already being administered.

ff. **Patient D.M.**

i. On or about October 21, 2002, Patient D.M.'s physician ordered Hydromorphone 2mg to be administered every 2 hours, as needed for severe pain.

ii. On or about October 22, 2002 at approximately 1248 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient D.M. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication.

gg. **Patient J.W.**

i. On or about October 20, 2002, Patient J.W.'s physician ordered Hydromorphone 1mg to be administered every 4 hours, as needed.

ii. On or about October 21, 2002 at approximately 0844 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient J.W. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or

otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

iii. On or about October 21, 2002, Respondent documented in the medical records that at 0800 hours, the patient had no complaints of pain.

hh. **Patient G.U.**

i. On or about October 18, 2002, Patient G.U.'s physician ordered Morphine 6mg to be administered every 2 hours, as needed for severe pain.

ii. On or about October 21, 2002 at approximately 1046 hours, Respondent obtained an 8mg dose of Morphine from the Omnicell system allegedly for administration to Patient G.U. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

iii. On or about October 21, 2002, Respondent documented in the medical records that at 1000 hours, Patient G.U. was resting quietly without complaints and that at 1200 hours, Vicodin was administered.

ii. **Patient G.P.**

i. On or about October 1, 2002, Patient G.P.'s physician ordered Hydromorphone 1mg to be administered every 2 hours, as needed, and Meperidine 10mg every hour as needed.

ii. On or about October 2, 2002 at approximately 0801, 1103, and 1301 hours, Respondent obtained a 2mg dose of Hydromorphone from the Omnicell system allegedly for administration to Patient G.P. Respondent failed to document the administration of the medication on the patient's medication administration record. Respondent failed to chart the wastage of or otherwise account for the medication. The amount of medication removed exceeded the amount indicated in the physician's orders. Patient G.P. was already being administered Meperidine, as discussed in subparagraph iii, below.

///

iii. On or about October 2, 2002 at approximately 0825, 1022, and 1103 hours, Respondent obtained a 50mg dose of Meperidine from the Omnicell system allegedly for administration to Patient G.P. Respondent documented the administration of the medication on the patient's medication administration record, however, Respondent failed to chart the wastage of or otherwise account for 40mg of the medication. The amount of medication removed exceeded the amount indicated in the physician's orders.

Art of Aesthetic Surgery

37. From January 26, 2006 to April 27, 2006, Respondent worked as a registered nurse at the Art of Aesthetic Surgery, a plastic surgery medical practice, located in Fremont, California. During the course of her employment, Respondent committed the following acts:

a. An Art of Aesthetic Surgery employee reported to the Fremont Police Department that 24 bottles of Demerol 100mg were empty but the tops had been glued back on, 3 Cocaine 4ml bottles had been opened and filled with clear fluid, 9 Fentanyl 5ml bottles were cracked and emptied, 1 Fentanyl 5ml bottle was cracked, 1 Morphine 15mg bottle was partially full of liquid and glued at the top of the bottle, 1 Midazolam 10ml bottle was partially full of liquid, and the office's narcotics log book was reported missing.

b. An Art of Aesthetic Surgery employee reported to the Fremont Police Department that during the time that Respondent was employed at the Art of Aesthetic Surgery, patients had made complaints regarding ineffective pain control.

c. Respondent admitted to an Art of Aesthetic Surgery employee that she was behind in her recording of controlled substance administration in the office narcotics log book.

d. On or about May 3, 2006, a search conducted under warrant by the Fremont Police Department of Respondent's home recovered the following: the missing narcotic log book from Art of Aesthetic Surgery; 200 hypodermic needles; empty vials; 2 syringes labeled Vecuronium; one syringe each labeled as Succinyl Choline, Ephedrine, and Neosynephrine; an empty bottle inside a box labeled Cocaine; a container of Fentanyl Citrate with six empty vials; a bottle of Midazolam Hydrochloride; and medication that was prescribed to persons other than

Respondent, including: 2 bottles of Cephalexin, 2 bottles of Furosemide, and 1 bottle each of Ciprofloxacin, Marionol, and Ambien.

d. Respondent admitted to the Fremont Police Department to taking bottles of narcotics from the Art of Aesthetic Surgery to her home, self-administering the narcotics, refilling the vials with saline, gluing the tops back on the vials, and returning the vials to the office.

Embezzlement Conviction

38. On or about December 14, 2006, in the criminal proceeding People v. Jennifer Lynn Bales, Alameda County Superior Court Case No. H42886, Respondent was convicted by a plea of no contest of violating Penal Code section 503 (Embezzlement), a felony criminal offense she committed from January 26, 2006 to April 27, 2006. the circumstances underlying the conviction involved Respondent's theft of controlled substances, dangerous drugs, and dangerous devices from the medical practice where she was employed, as set forth in Paragraph 37, above.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

39. Complainant realleges the allegations set forth in paragraph 36 and its sub-parts, above, which are herein incorporated by reference as though fully set forth.

40. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), of the Code for unprofessional conduct, as defined by California Code of Regulations, title 16, section 1442, in that while employed as a registered nurse at San Ramon Regional Medical Center in San Ramon, California, she committed acts of gross negligence in carrying out her usual certified or licensed nursing functions. Specifically, respondent was grossly negligent in that on the occasions more particularly set forth in paragraph 36 and its sub-parts, above, she committed the following acts:

a. Failed to account for controlled substances;

b. Failed to accurately document the care provided (the amount of narcotic medications that she purportedly administered);

c. Withheld care from a patient (in the form of pain relief);

d. Diverted narcotic medications from the San Ramon Regional Medical Center; and

e. Falsified patient records upon which the patients are billed (fraud).

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Obtaining and/or Possessing Controlled Substances or Dangerous Drugs)

41. Complainant realleges the allegations set forth in paragraphs 36 and 37 and their sub-parts, above, which are herein incorporated by reference as though fully set forth.

42. Respondent's registered nurse license is subject to discipline under section 2761, subdivision (a), of the Code for unprofessional conduct, as defined by Code section 2762, subdivision (a), in that while employed as a registered nurse at San Ramon Regional Medical Center in San Ramon, California, and at the Art of Aesthetic Surgery in Fremont, California, she committed the following acts:

a. Respondent unlawfully obtained and possessed the following controlled substances in violation of Code section 4060: Ambien, Cocaine, Fentanyl, Hydromorphone, Lorazepam, Lortab, Marionol, Meperidine, Morphine, Midazolam, and Vicodin.

b. Respondent unlawfully obtained the following controlled substances by fraud, deceit, misrepresentation, subterfuge and/or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a): Ambien, Cocaine, Fentanyl, Hydromorphone, Lorazepam, Lortab, Marionol, Meperidine, Morphine, Midazolam, and Vicodin.

c. Respondent unlawfully obtained and possessed the following dangerous drugs: Cephalexin, Ciprofloxacin, Ephedrine, Furosemide, Neo-Synephrine, Succinyl Choline, and Vecuronium.

d. Respondent unlawfully obtained and possessed the following dangerous devices: syringes and hypodermic needles.

///

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Falsify or Make Incorrect or Inconsistent Entries in Records)

43. Complainant realleges the allegations set forth in paragraphs 36 and 37 and their sub-parts, above, which are herein incorporated by reference as though fully set forth.

44. Respondent's registered nurse license is subject to discipline under section 2761, subdivision (a), of the Code for unprofessional conduct, as defined by Code section 2761, subdivision (e), and Health and Safety Code section 11190, in that while employed as a registered nurse at San Ramon Regional Medical Center in San Ramon, California, and at the Art of Aesthetic Surgery in Fremont, California, she made false, grossly incorrect, and/or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and dangerous drugs as set forth in paragraphs 36 and 37, above.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Use of Controlled Substances)

45. Complainant realleges the allegations set forth in paragraph 37 and its sub-parts, above, which are herein incorporated by reference as though fully set forth.

46. Respondent's registered nurse license is subject to discipline under section 2761, subdivision (a), of the Code for unprofessional conduct, as defined by Code section 2762, subdivision (b), in that while employed as a registered nurse at the Art of Aesthetic Surgery in Fremont, California, she admittedly used controlled substances and dangerous drugs and dangerous devices to an extent or in a manner dangerous or injurious to herself, any other person, or the public or to the extent that such use impaired her ability to conduct with safety to the public the practice authorized by her license, as set forth in paragraph 37, above.

///

///

///

///

///

FIFTH CAUSE FOR DISCIPLINE

(Conviction of Crime Substantially Related to Registered Nursing)

47. Complainant realleges the allegations set forth in paragraphs 37 and 38 and their sub-parts, above, which are herein incorporated by reference as though fully set forth.

48. Respondent is subject to disciplinary action under sections 490 and 2761, subdivision (f), of the Code in that she was convicted of an offense substantially related to the qualifications, functions, and duties of a Registered Nurse, within the meaning of California Code of Regulations, title 16, section 1444, as set forth in more detail in paragraph 38, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 583667, issued to Jennifer Lynn Bales.

2. Ordering Jennifer Lynn Bales to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/14/07

Ruth Ann Terry for
RUTH ANN TERRY, M.P.H, R.N
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant